



University Hospitals

Employee Assistance Program
Conditions of Employment

Compliance Contract

between

Frank Dundee

Employee

and the

Employee Assistance Program Counselor

I understand that my supervisor referred me to the Employee Assistance Program (EAP) as a Mandatory Referral. I understand that my EAP assessment resulted in certain recommendations and I must comply with them.

I understand that my compliance with the EAP attendance recommendation and treatment plan must be monitored as determined by the EAP counselor. If I do not comply with the recommendation and/or treatment plan within ____ week (s) my supervisor and /or HR will be informed. Non-compliance may result in corrective action up to and including discharge.

The EAP recommendation/treatment plan requirements are as follows:

Attend evaluation with Warren Rubin, Ph.D
Follow recommendations. Follow-up with
EAP as scheduled.

I understand and agree to comply with the conditions of this Contract.

FRANK DUNDEE

Employee

7-26-17

Date

David Riccardo

EAP Counselor

7/26/17

Date

ATTACHMENT A**Authorization for Release of Medical Information**

University Hospitals

**AUTHORIZATION FOR RELEASE
OF MEDICAL INFORMATION**

Records to be released from:

Cleveland Medical Center ☐ Anuja ☐ Bedford ☐ Connecticut ☐ Geneva ☐ Highland ☒ Richmond ☐ UH Home Care ☐ UHFS ☐Patient Name DWIGHT Phelan
(Please Print) Last First MIDate of Birth 3-17-53 Social Security Number (last four digits) _____Address 7707 Cumberland Tr Phone Number (330) 726-2602
Boulder, CO Medical Record Number _____
Prior MR # _____Treatment Date(s) 7-26-17Please Release Medical Information to the Following Recipient: Warren Salter, Ph.D.
Name of Person or Organization _____ Phone # _____
Address _____ Mailstop _____
City _____ State _____ Zip Code _____ Fax # _____Purpose of Disclosure Evaluation ☐ For patient's request**Description of Information to be Released:**

<input type="checkbox"/> Patient Summary (includes all items)	<input type="checkbox"/> Radiology Report	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Admission Form	<input type="checkbox"/> Lab Report	<input type="checkbox"/> Radiology Report
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> EKG Report	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> Emergency Room Report	<input type="checkbox"/> Pathology Report	<input type="checkbox"/> Card Cath Report
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Card Cath Report	
<input type="checkbox"/> Consultation Report		
<input type="checkbox"/> Operative Report		

I, the undersigned, authorize UHF EAP to release information from my medical records as described above. I understand that the medical records may contain information regarding psychiatric disorders, human immune virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence issues. I also understand that information used to be released according to this authorization may be subject to redaction by the recipient and may no longer be protected. My failure to sign this authorization may result in my information not being released.

I understand that I have a right to revoke this authorization at any time. I understand that I reserve the right to withdraw my written consent to the release of information to the recipient. I understand that this revocation will not apply to information that has already been released in response to this authorization. I understand that this revocation will not apply to my insurance company if the law provides my insurer with the right to receive information. I understand that this revocation will not apply to the following date, event, or condition: _____ If I fail to specify a date, event, or condition, this authorization will expire on the date.

I warrant that treatment, payment, enrollment, or eligibility for benefits will not be conditional on my failure to sign this authorization.

I warrant that there may be charges for the review and release of information and potential for actual responsibility.

x [Signature] 7-26-17
Signature of Patient Legal Representative Date Signed

☐ Patient Unable to Sign

Description of Legal Representative's Authority to Act on Behalf of Patient (if applicable)

I, the undersigned, agree to act on behalf of the patient and to execute the patient's authorization to release information.



HIM13018



ATTACHMENT A**Authorization for Release of Medical Information**

University Hospitals

**AUTHORIZATION FOR RELEASE
OF MEDICAL INFORMATION**

Records to be released from:

Cleveland Medical Center ☐ Ahuja ☐ Bedford ☐ Cernaunt ☐ Geneva ☐ Geauga ☒ Richmond ☐ UH Home Care ☐ UHPS ☐Patient Name DUNDEE FRANK
(Please Print) (Last) (First) (MI)Date of Birth 9-17-53 Social Security Number (last four digits) _____Address 7707 Cumberland Tr Phone Number (330) 726-2662
Barabara, OH Medical Record Number _____
Prior MR # _____Treatment Dates: 1-26-17

Please Release Medical Information to the Following Recipient:

Name of Person or Organization _____ Phone # _____
Address _____ Mailstop _____
City _____ State _____ Zip Code _____ Fax # _____Purpose of Disclosure Medication Management ☐ If the patient is insured**Description of Information to be Released:**☐ Patient Summary, includes all items☐ Access to Files☐ Discharge Summary☐ Emergency Room Report☐ History & Physical☐ Consultation Report☐ Operative Report☐ Radiologist's Reading Report☐ Lab Reports☐ Radiology Report☐ EKG Report☐ Pathology Report☐ Card Cath Report☐ Physical Therapy☐ Nurse Report☐ Physician's Notes☐ Other _____

I, the undersigned, authorize UH EAP (Disclosure) to disclose, and its employees to release information from my medical records as described above. I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse. I also understand that information used or disclosed according to this authorization may be subject to redaction by the recipient and may or may not be returned. My failure to sign this authorization may result in my information not being released.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to any insurance company when the way provides my insurer with the right to contest a claim under my policy. Unless otherwise restricted by a restriction on release on the following date, event, or condition _____, this authorization will expire on the year _____.

I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization. I understand that there may be charges for the copying and release of information, and accept financial responsibility.

x Declined
Signature of Patient Legal Representative

Date Signed _____

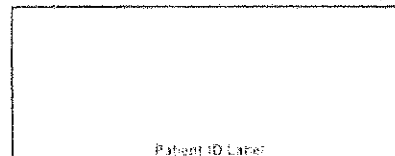
☐ Patient unable to sign

Description of Legal Representative's Authority to Act on Behalf of Patient (if applicable)

I have been named as the legal representative of the patient and hereby authorize the release of information as described above.



HIM13018



Authorization for Release of Medical Information



University Hospitals

AUTHORIZATION FOR RELEASE
OF MEDICAL INFORMATION

Records to be released from:

Cleveland Medical Center ☐ Abuja ☐ Bedford ☐ Connecticut ☐ Geneva ☐ Geauga ☒ Richmond ☐ UH Home Care ☐ UHPS ☐

Patient Name: DUWEL, FRANK
Please Print: FRANK

Date of Birth 8-17-53 Social Security Number (last four digits) _____

Address 7707 Amerwood Dr Phone Number (339) 726-2662
West Haven, Ct Medical Record Number _____
 Prior MR # _____

Treatment Dates: 7-26-17 1

Please Release Medical Information to the Following Recipient: *for Carol*

Name of Person or Organization *Alfred E. ...* Phone # _____

Address _____ Mailstop _____

City State Zip Code

Purpose of Disclosure for 411 Compliance, Wisconsin and Federal Tax Reporting

Description of Information to be Released:

<input type="checkbox"/> Discharge Summary <input type="checkbox"/> Emergency Room Report <input type="checkbox"/> History & Physical <input type="checkbox"/> Consultation Report <input type="checkbox"/> Operative Report	<input type="checkbox"/> Radiology Report <input type="checkbox"/> EKG Report <input type="checkbox"/> Pathology Report <input type="checkbox"/> Card Cath Report	<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Nurse Report <input type="checkbox"/> Physician's Notes <input type="checkbox"/> Other
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U17 EAP

discussing "individuals and to employees a
information from my medical records and that in the course and acknowledge that the medical records contain
information regarding psychiatric treatment information on this. However results Assessed Intimate Disclosure Syndrome (AIDS
AIDS-related conditions, alcohol, and drug use, and other information used is disclosed according to its
authorization may be subject to review as by the recipient and may not be properly protected. My failure to sign this authorization may
result in my information not being provided.

[illegible]

Diebstahl der Handlung: ein gewalttätiger Angriff auf das Leben des Angeklagten durch den Angeklagten selbst am 17. September 1908

Understand there may be changes in the target and message. Information and acceptance must be reassessed.

Signature of Parent/Local Representative:

Date 3/2/2000

☐ Patient unable to sign

Description of Legal Representative's Authority to Act on Behalf of Patient, if applicable:

[illegible]

"HIM13018"

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ATTACHMENT A**Authorization for Release of Medical Information**

University Hospitals

**AUTHORIZATION FOR RELEASE
OF MEDICAL INFORMATION**

Records to be released from:

Cleveland Medical Center ☐ Anuja ☐ Bedford ☐ Cerner ☐ Geneva ☐ Geauga ☒ Richmond ☐ UH Home Care ☐ UHPS ☐Patient Name DUNDEE ERIN
Please Print Last First MIDate of Birth 8-17-53 Social Security Number (last four digits) _____Address 7707 Amburnood Dr Phone Number (330) 726-2662
Bedford, OH Medical Record Number _____
Page MR # _____Treatment Dates: 7-24-17Please Release Medical Information to the Following Recipient
Name of Person or Organization Female Pence Phone # _____
Address _____ Mailstop _____
City _____ State _____ Zip Code _____ Fax # _____Purpose of Disclosure EA Compliance, Remediation**Description of Information to be Released:**

<input type="checkbox"/> Admission Summary	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Radiology Report
<input type="checkbox"/> Emergency Room Report	<input type="checkbox"/> Radiology Report	<input type="checkbox"/> EKG Report
<input type="checkbox"/> History & Physical	<input type="checkbox"/> EKG Report	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> Consultation Report	<input type="checkbox"/> Pathology Report	<input type="checkbox"/> Card Cath Report
<input type="checkbox"/> Operative Report	<input type="checkbox"/> Card Cath Report	<input type="checkbox"/> Other _____

I, the undersigned, authorize UH EA to release information from my medical record as described above. I understand and acknowledge that the medical information regarding psychiatric disorders, human immunodeficiency virus, test results, acquired immunodeficiency syndrome (AIDS), AIDS-related conditions, alcohol and drug dependence/abuse, status post test that information used is disclosed in writing to the authorized party for study or to be included as by the recipient and may no longer be protected. My failure to sign this authorization may result in my information not being released.

I understand that I have a right to revoke this authorization at any time. I understand that I have signed this authorization in good faith, and I understand that the information that has been released is for the purpose of the information that has been released. I understand that the information that has been released is for the purpose of the information that has been released. I understand that the information that has been released is for the purpose of the information that has been released.

I understand that I have a right to revoke this authorization at any time. I understand that I have signed this authorization in good faith, and I understand that the information that has been released is for the purpose of the information that has been released.

I understand that I have a right to revoke this authorization at any time. I understand that I have signed this authorization in good faith, and I understand that the information that has been released is for the purpose of the information that has been released.

x [Signature] 7-26-17
Signature of Patient Legal Representative Date Signed

☐ Patient unable to sign

Description of Legal Representative's Authority to Act on Behalf of Patient (if applicable)

I am the legal representative of the patient and I am authorized to act on behalf of the patient in the release of medical information.



HIM13018



Patient ID Label